Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l’inspection	Log # / Registre no	Type of Inspection / Genre d’inspection
Oct 25, 2016	2016_282543_0024	012988-16, 014176-16, 019493-16, 019615-16	Complaint

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE YORK
333 YORK STREET SUDBURY ON P3E 5J3

Name of Inspector(s)/Nom de l’inspecteur ou des inspecteurs

TIFFANY BOUCHER (543), CHAD CAMPS (609), MISHA BALCIUNAS (637)

Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 26-29, http://localhost:41003/CSC/Inspection/InspectionSelector.aspxAugust 2-5 and August 8-9, 2016.

This Complaint Inspection is related to four complaints; all related to resident care.

A Critical Incident (CI) Inspection #2016_282543_0023 was conducted concurrently with this inspection.

The Inspector(s) conducted a daily walk through of resident areas, observed the provision of care towards residents, observed staff to residents interactions, reviewed residents’ health care records, staffing schedules, policies, procedures, programs, and staff personnel files.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Director(s) of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Dietary Manager, the Support Service Manager, the Educational Co-ordinator and the Office Manager.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A complaint was submitted to the Director in June, 2016, related to the failure to provide resident care. According to the complaint, it was reported that direct care staff had not been assisting resident #004 with specific activities of daily living.

Inspector #543 reviewed resident #004's most recent care plan which indicated, related to personal hygiene, that the resident required assistance from staff to perform duties related to activities of daily living . The care plan also indicated that resident #004 would receive the necessary assistance from staff.

On July 29, 2016, the Inspector spoke with PSW #111 who confirmed that they had not performed a certain task related to personal hygiene for resident #004 during the week of July 15-19, 2016.

On August 2, 2016, the Inspector spoke with the resident's family, who stated that the resident had difficulty performing specific activities of daily living related to personal hygiene on their own and would appreciate staff assistance for that particular task.

On August 3, 2016, the Inspector spoke with PSW #117 who stated that they would perform specific activities of daily living on their shower day. [s. 6. (7)]

2. A critical incident (CI), submitted to the Director in July, 2016, described the unexpected death of resident #001.

According to the CI report, resident #001 was in the dining room, and was choking on their food. The CI report described that the Nurse in Charge was called and observed that the resident was not responding. Paramedics were called for assistance and CPR had been initiated by staff in the home and halted by paramedics. Paramedics reassessed the resident, whose vital signs were absent.

Inspector #543 reviewed resident #001's most recent care plan, which indicated under the eating focus that this resident required supervision related to impairments.

During an interview, PSW #104 stated that seating arrangements in the dining room had recently been changed, where all the independent or more independent residents were kept to one side of the dining room with only one PSW and an RPN. Prior to the change, the seating arrangement was more scattered and was safer, as there were "more eyes" on all the residents to facilitate supervision.

In an interview with PSW #105, they stated that resident #001 had not been supervised at the meal time. They verified that the floor was working in Plan B, short one PSW. They stated that resident #001 was seated in a area in the dining room where nobody could directly see the resident's face. The PSW further stated that staff were working short a PSW, and normally the RPN would have been in resident #001's section but they had been serving other residents. PSW #105 indicated that usually when a floor was short staffed, a PSW from other floors would come to with the meal service; however, on that day in particular that had not occurred.

There is currently an outstanding order related to LTCHA, 2007 s. 6 (7), from Resident Quality Inspection Report #2016_391603_0007. [s. 6. (7)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A complaint was submitted to the Director in July, 2016, which alleged that on a day in July, 2016, PSW #122 had performed a task for resident #012 without prior warning which caused the resident distress.

Inspector #609 reviewed the home's internal investigation which revealed that PSW #122 had had performed a task for resident #012 without prior warning which caused the resident distress.

A review of the home's document titled "Extendicare's Commitment to Residents- Zero Tolerance Appendix 1", last updated October 2015, which indicated that each resident was to be treated with courtesy, respect and dignity, free from mental and physical abuse.

A review of PSW #122's letter of discipline, indicated that they had performed a task for resident #012 without prior warning which caused the resident distress.

During an interview with the DOC on August 4, 2016, they verified that the home's internal investigation identified that PSW #122 physically abused resident #012 and they had not complied with the home's zero tolerance of abuse policy. [s. 20. (1)]

2. A critical incident (CI) report, was submitted to the Director in May, 2016, which stated that PSW #119 had overheard PSW #118 being verbally abusive towards resident #008.

On August 3, 2016, Inspector #637 interviewed PSW #119, who stated that they overheard PSW #118 speaking in an inappropriate manner with resident #008.

On August 4, 2016, Inspector #637 interviewed the DOC who verified that PSW #118 had violated the home's zero tolerance of abuse policy by speaking in an inappropriate manner towards resident #008 and that it was the home's expectation that all staff complied with the home's zero tolerance of abuse policy.

There is currently an outstanding order related to LTCHA, 2007 s. 20 (1), from Resident Quality Inspection Report #2016_391603_0007. [s. 20. (1)]

Issued on this 26th day of October, 2016

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.